

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-011160

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1298

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 26 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF Frank Paul Laurencz MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in lb <u>53 years</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Linwood Nursing Home</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1900 Linwood</u>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bertie</u> Middle <u>NAOMA</u> Last <u>Mc COWN</u>						4. DATE OF DEATH Month <u>MARCH</u> Day <u>3</u> Year <u>1962</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 23 - 1875</u>		9. AGE (last birthday) <u>86</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Danville, Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>William B. Watts</u>				13b. MOTHER'S MAIDEN NAME <u>Sarah Mc Callough</u>				14. NAME OF HUSBAND OR WIFE <u>John R. Mc Cown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>MR. Roy Mc Cown</u>		Address <u>6626 Montgall</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>										<u>2 days</u>	
DUE TO (b) <u>Chronic Myocarditis</u>										<u>6 years</u>	
DUE TO (c) <u>Arteriosclerosis</u>										<u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART-I or PART II of item 18.)						
20c. TIME OF INJURY Hour <u>8:30</u> a.m. p.m.		Month, Day, Year <u>12-16-61</u>			20f. CITY, TOWN, OR LOCATION <u>Kansas City Missouri</u>						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION <u>Kansas City Missouri</u>						
21. I attended the deceased from <u>12-16-61</u> to <u>3-3-62</u> and last saw her alive on <u>3-3-62</u> Death occurred at <u>8:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <u>Frank Paul Laurencz M.D.</u>						22b. ADDRESS <u>428 So White Ave</u>			22c. DATE SIGNED <u>3-3-62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>MARCH 6, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>		23d. LOCATION (City, town, or county) <u>Kansas City Missouri</u>			23e. STATE <u>Missouri</u>		
24. FUNERAL DIRECTOR <u>Muehlebach</u>				ADDRESS <u>6800 TRUST</u>		25. DATE RECD. BY LOCAL REG. <u>3-5-62</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>			

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Sawanara
Memorial Emergency Room
Re 1-3319

MEMORIAL HOSPITAL

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed R. E. Nichols

Licensed Embalmer No. 4997

P. O. Address V. C. MO.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.